

Resolution No.: 16-1111
Introduced: September 22, 2009
Adopted: September 22, 2009

**COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND**

By: County Council

SUBJECT: Approval of Executive Regulation 7-09, Military Family Leave and Other Family and Medical Leave Amendments to the 2001 Montgomery County Personnel Regulations

Background

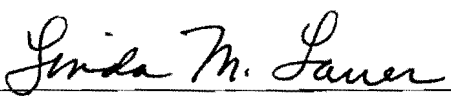
1. On June 22, 2009, the County Council received Executive Regulation 7-09 to amend Section 19 of the Personnel Regulations to include military family leave entitlements provided under federal law and to reflect the final rules issued by the U.S. Department of Labor which covers the new military family leave, as well as updates and clarifies Family Medical Leave Act (FMLA) regulations.
2. Executive Regulation 7-09 is processed under Method 1, and is not adopted until the County Council approves it.
3. The proposed amendments were advertised in the April 2009 Montgomery County Register and no comments were received. The Merit System Protection Board reviewed the proposed amendments and has no objections.
4. The Management and Fiscal Policy Committee reviewed Executive Regulation 7-09 on September 14, 2009, and recommended approval as submitted

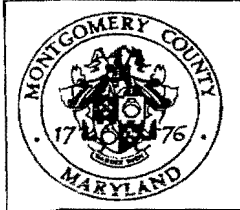
Action

The County Council for Montgomery County, Maryland approves the following resolution:

Executive Regulation 7-09, Military Family Leave and Other Family & Medical Leave Amendments to the 2001 Montgomery County Personnel Regulations, is approved.

This is a correct copy of Council action.


Linda M. Lauer, Clerk of the Council



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| Subject | Military Family Leave and Other Family and Medical Leave Amendments to the 2001 Montgomery County Personnel Regulations | Number | 7-09 |
| Originating Department | Office of Human Resources | Effective Date | September 22, 2009 |

Military Family Leave and Other Family and Medical Leave Amendments to the 2001 Montgomery County Personnel Regulations

Executive Regulation No. 7-09

Issued by: County Executive

Supersedes: Executive Regulation No. 12-00AMII, in part

Authority: Montgomery County Code, 2004, §33-7(b)

Council review: Method 1

Montgomery County Register Volume 26, Issue 4

Comment deadline: April 30, 2009

Effective date: September 22, 2009

Summary: This regulation amends Section 19 of the 2001 Montgomery County Personnel Regulations to encompass new military family leave entitlements included in amendments to the Family and Medical Leave Act of 1993 (FMLA) enacted as part of the National Defense Authorization Act for FY 2008 that was signed into law by President Bush on January 28, 2008. The changes in this regulation also reflect the final rule issued by the U.S. Department of Labor on November 17, 2008, updating and clarifying its FMLA regulations.

Address for comments Office of Human Resources, Executive Office Building, 7th Floor
101 Monroe Street, Rockville, Maryland 20850

Staff contact: Stuart Weisberg, 240-777-5051, or stuart.weisberg@montgomerycountymd.gov

This is a clean copy of the regulation that shows how it will appear after the amendments are incorporated. Use the key below when reading this regulation:

Boldface
* * *

Heading or defined term.
Existing language unchanged by executive regulation.



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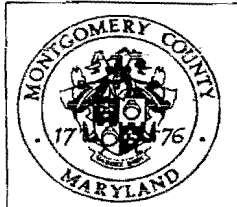
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SECTION 19. FAMILY AND MEDICAL LEAVE

19-1. Definitions.

- (a) **Active duty or call to active duty status:** Military duty under a call or order to active duty (or notification of an impending call or order to active duty) as a member of the National Guard or state militia, a member of a reserve component of the Armed Forces of the United States, or as a retired member of the Armed Forces or the Reserve under certain sections of Title 10 of the United States Code identified and discussed in 29 CFR Sec. 825.126(b)(2).
- (b) **Contingency operation:** A military operation designated by the Secretary of Defense as one in which members of the Armed Forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.
- (c) **Daughter or son:** An employee's biological, adopted, or foster child, stepchild, domestic partner's child, legal ward, or child for whom the employee stands in loco parentis and:
 - (1) for purposes of regular family leave:
 - (i) who is under 18 years of age, or
 - (ii) 18 years of age or older and incapable of self-care because of a mental or physical disability at the time leave is to begin;
 - (2) who is of any age for purposes of military family leave:
- (d) **Extenuating circumstances:** Circumstances that prevent the follow-up visit from occurring as planned by the health care provider (e.g., if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period).



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(e) **Health care provider:** A doctor of medicine or osteopathy who is authorized to practice medicine or surgery, as appropriate, by the State in which the doctor practices or another person capable of providing health care services, such as a podiatrist, dentist, clinical psychologist, optometrist, chiropractor, nurse practitioner, nurse midwife, clinical social worker, physician assistant, or Christian Science practitioner.

(f) **Next of kin:** The nearest blood relative other than the covered servicemember's spouse, domestic partner, parent, son, or daughter, in the following order of priority unless the servicemember has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under FMLA:

- (1) blood relatives who have been granted legal custody of the covered servicemember by court decree or statutory provisions;
- (2) brothers and sisters;
- (3) grandparents;
- (4) aunts and uncles; and
- (5) first cousins.

(g) **Parent:** The biological, adoptive, step or foster mother or father of an employee or an individual who stands or stood in loco parentis to the employee when the employee was a child.

(h) **Serious health condition:**

- (1) an illness, injury, impairment, or physical or mental condition that involves one of the following:

* * *

(D) a chronic condition that:



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- (i) requires visits at least twice a year for treatment by a health care provider or by a nurse or physician's assistant under the direct supervision of a health care provider;
- (ii) continues over an extended period of time (including recurring episodes of a single underlying condition; or
- (iii) may cause episodic incapacity rather than a continuing period of incapacity (e.g., asthma, diabetes, or epilepsy).

* * *

- (2) The following terms used in the definition of "serious health condition" are defined as follows:

- (A) **Absence plus treatment:** A period of incapacity of more than 3 consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:

- (i) treatment 2 or more times by a health care provider, by a nurse, or physician's assistant under the direct supervision of a health care provider, or by a provider of health care services such as a physical therapist under orders of, or on referral by, a health care provider, within 30 days of the beginning of the period of incapacity, unless extenuating circumstances exist, (with the first treatment taking place within 7 days of the first day of incapacity and the need for a second treatment being determined by the health care provider and not the employee or patient); or



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(ii) treatment by a health care provider on at least one occasion, within 7 days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider.

(B) **Continuing treatment by a health care provider:**

Treatment 2 or more times within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider or by a provider of health care services under the direct supervision of a health care provider or treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of a health care provider.

* * *

(F) **Treatment:** Includes but is not limited to an in-person visit to a health care provider for an examination to determine if a serious health condition exists or evaluation of a condition but does not include a routine physical, eye, or dental examination.

19-2. Intent under FMLA. It is the County's intent that this section be:

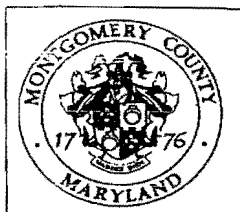
(a) used to implement the FMLA of 1993, as amended; and

* * *

19-3. Eligibility for FMLA leave. An employee is eligible to use FMLA leave if the employee:

(a) has a total of at least 12 months of County employment, if past (going back 7 years) and present County employment are combined;

* * *



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- (d) provides medical certification, if requested, as described in Section 19-9(b)(2), or as described in Section 19-12(b), if applicable, and

* * *

19-4. Amount of FMLA leave.

* * *

- (d) A supervisor must not count time that an employee spends performing light duty work as FMLA leave.

* * *

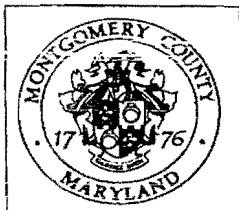
19-6. Authorized reasons for using FMLA leave. An eligible employee may use FMLA leave for any of the following reasons:

* * *

- (d) to care for, which may include providing psychological comfort and reassurance, or arrange care for, any of the following with a serious health condition: the employee's spouse, domestic partner, parent, daughter, or son;
- (e) because of the employee's serious health condition that makes the employee unable to perform the essential function of the employee's position;
- (f) to handle an exigency arising from the employee's spouse, domestic partner, parent, daughter, or son serving on active duty under a call or order or being notified of an impending call or order to active duty in support of a contingency operation as described in Section 19-11(b); or
- (g) to care for the employee's spouse, domestic partner, parent, daughter, son, or next of kin on active duty with a serious injury or illness incurred in the line of duty as described in Section 19-11(a).

19-7. Application for FMLA leave and notice required of employee.

- (a) **Application for leave.** An employee must apply for FMLA leave by completing a County *Employee Request for FMLA Leave Form* (Appendix U)



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and submitting the form to the employee's supervisor.

(b) ***Notice required of employee.***

* * *

- (3) if an employee could not foresee the need to use leave for an FMLA purpose, the employee must give the supervisor notice as soon as possible and must follow the department's usual and customary call-in procedures for reporting an absence, absent unusual circumstances.

19-8. Supervisor's responsibility for designating leave as FMLA leave.

(a) ***Supervisor's initial designation of leave.***

* * *

- (3) A supervisor must designate leave as FMLA leave within 5 working days after an employee requests leave for an FMLA purpose.

* * *

- (c) ***Information that a supervisor must give to an employee.*** Within 5 working days after an employee requests leave for an FMLA purpose, the supervisor must inform the employee of:

* * *

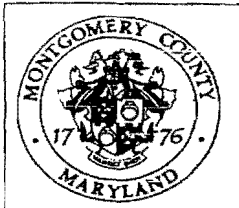
19-9. Use of FMLA leave.

* * *

(b) ***FMLA leave taken for a serious health condition.***

* * *

- (2) A supervisor may require an employee to submit a County *Medical Certification of Employee's Serious Health Condition Form* (Appendix P-1) or a County *Medical Certification of Family Member's Serious Health Condition Form* (Appendix P-2) to support a request for leave for a serious health condition.



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19-11. Use of military family leave.

(a) *Use of FMLA leave to care for a servicemember with a serious injury or illness.*

- (1) An eligible employee whose spouse, domestic partner, parent, son, daughter, or next of kin is a current member of the Armed Forces, including a member of the National Guard or Reserves, may use up to 26 workweeks of leave to care for the servicemember, if the servicemember:
 - (A) has a serious injury or illness that was incurred in the line of duty while on active duty; and is
 - (B)
 - (i) undergoing medical treatment, recuperation, or therapy;
 - (ii) otherwise in outpatient status; or
 - (iii) otherwise on the military temporary disability retired list.
- (2) The up to 26 workweeks of leave under Section 19-11(a)(1) must be taken by the employee during a single 12-month period. The leave period begins on the first day the employee takes leave to care for a covered servicemember and ends 12 months after that date.
- (3) If an employee does not take all of the 26 weeks of military caregiver leave during the applicable single 12-month period, the balance is forfeited and no-carryover is permitted.
- (4) After the single 12-month period expires, the employee is eligible for another 26 weeks of military caregiver leave during a subsequent single 12-month period to care for a different covered servicemember or to care for the same covered servicemember if that person incurs a different serious injury or illness.



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- (5) Leave to care for a covered servicemember with a serious injury or illness under Section 19-11(a) may be taken continuously, intermittently, or on a reduced schedule basis.
- (6) An employee is entitled to a combined total of 26 workweeks of military caregiver leave and leave for any other FMLA-qualifying reason, provided that the employee may not take more than 12 workweeks of leave for any other FMLA-qualifying reason during the calendar year.
- (b) ***Use of FMLA leave to handle exigencies directly related to a close family member's active duty status or call to active duty.***
 - (1) An eligible employee whose spouse, domestic partner, son, daughter, or parent has been called or ordered to active duty or has been notified of an impending order to active duty may use up to 12 workweeks of leave because of any of the following qualifying reasons:
 - (A) to deal with an issue that arises because of a short-notice deployment when a military member is notified of an order to active duty with 7 or less calendar days of notice of the deployment;
 - (B) to attend a military event or related activity, such as an official ceremony, program, or event sponsored by the military, a family support or assistance program, or an informational briefing sponsored or promoted by the military, military service organizations, or the American Red Cross;
 - (C) to deal with an issue concerning childcare or school activities that arise from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on an urgent, immediate need basis (but not on



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a routine, regular, or everyday basis), enrolling in or transferring to a new school or day care facility, or attending a meeting with staff at a school or daycare facility;

- (D) to make a financial or legal arrangement, such as preparing or executing a financial or healthcare power of attorney, preparing or updating a will or living trust, transferring a bank account signature authority, or obtaining a military identification card;
 - (E) to obtain counseling, such as attending a counseling session provided by someone other than a healthcare provider;
 - (F) to spend time with a covered military member who is on short term temporary leave for rest and recuperation while on active duty;
 - (G) to participate in a post-deployment activity, such as attending an arrival ceremony, reintegration briefing, or any other official ceremony or program sponsored by the military within a period of 90 days after the end of the military member's active duty status;
 - (H) to address issues that arise from the death of a covered military member while on active duty status; and
 - (I) to deal with any other event that arises out of the covered service member's active duty or call to active duty status if the employer and employee agree:
 - (i) that the event qualifies as an exigency, and
 - (ii) on both the timing and duration of the leave.
- (2) An employee may use leave to deal with an issue arising from a service member's short-notice deployment for no more than 7 calendar days after receiving the notice of deployment.



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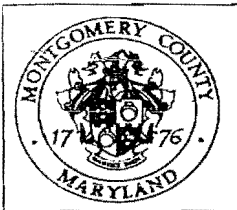
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- (3) An employee may use leave to spend time with a covered military member who is on short term temporary leave for rest and recuperation while on active duty for no longer than 5 days for each instance.
- (4) A supervisor must count all hours of leave that an employee uses to handle issues arising from a close family member's being called or ordered to active duty military service against the employee's FMLA entitlement of 12 weeks in a leave year.

19-12. Application for military family leave.

- (a) **Application for leave for a qualified exigency.** A supervisor may require an employee requesting FMLA leave due to a qualifying military exigency to submit a *County Certification of Qualifying Exigency For Military Family Leave Form* (Appendix S). The certification should include the following information:
 - (1) a statement signed by the employee describing the nature and details of the specific exigency, the amount of leave needed, and the employee's relationship to the military member;
 - (2) a copy of the covered military member's active duty orders;
 - (3) a description of the facts supporting the leave request, including any available documentation such as a copy of a meeting announcement or copy of a bill (e.g., for financial or legal services);
 - (4) the approximate date the qualifying exigency began or will begin;
 - (5) if the request is for a single period of time, the beginning and end dates for the absence;
 - (6) if the request is for intermittent or reduced schedule basis, an estimate of the frequency and duration of exigency;



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- (7) if the exigency involves meeting with a third party or entity, contact information for the third party or entity and a brief description of the purpose of the meeting.

(b) **Application for military caregiver leave.**

- (1) A supervisor may require an employee who requests FMLA leave to care for a servicemember to submit a *County Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave Form* (Appendix T) indicating that the servicemember has a serious illness or injury incurred in the line of duty on active duty and is undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for the serious illness or injury incurred in the line of duty on active duty.
- (2) Medical certification may be provided by:
- (A) a United States Department of Defense (DOD) health care provider;
 - (B) a United States Department of Veterans Affairs health care provider;
 - (C) a DOD TRICARE network authorized private health care provider; or
 - (D) a DOD non-network TRICARE authorized health care provider.
- (3) The supervisor may require confirmation of the employee's family relationship with the servicemember.
- (4) The supervisor may deny FMLA leave if the employee fails to provide complete certification as required by these Regulations upon request.

19-13. Limits on the use of sick leave as FMLA leave.



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19.14. Transfer of employee on FMLA leave.

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19.15. Recording of FMLA leave.

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19.16. Relation of FMLA leave to other benefits.

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19.17. Reinstatement of an employee after FMLA leave.

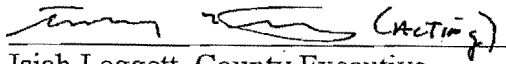
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19.18. Rights under FMLA of an employee after military service

* * *

19.19. Appeal of FMLA leave decision.

* * *

Approved:  (Acting)
Isiah Leggett, County Executive

6/20/2009
Date

Approved as to form and legality:

Anne T. Windlee 5/18/09
Office of the County Attorney Date

SECTION 1: For Completion by the EMPLOYEE

SECTION II: For Completion by the HEALTHCARE PROVIDER

PART A: MEDICAL FACTS

Montgomery County Office of Human Resources

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ Yes ☐ No. If yes, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No.

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ Yes ☐ No. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ☐ Yes ☐ No. If yes, expected delivery date:

3. Use the information provided in Section I to answer this question.

Is the employee unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ Yes ___ No.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ Yes ___ No.

If so, are the treatments or the reduced number of hours of work medically necessary?
___ Yes ___ No.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ Yes ___ No.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ Yes ___ No. If yes, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date _____

SECTION I. For Completion by the EMPLOYEE

Date _____

SECTION II: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax : (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ Yes ___ No. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___ Yes ___ No.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ Yes ___ No.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

___ Yes ___ No. If yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ Yes ___ No. If yes, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B. AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs; or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ☐ Yes ☐ No.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
☐ Yes ☐ No.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____ Yes ____ No.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____ week(s) ____ month(s).

Duration: ____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____ Yes ____ No.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION-IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date



Montgomery County Government
Certification of Qualifying Exigency Military Family Leave
(Family and Medical Leave Act of 1993)

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military family leave due to a qualifying exigency to submit a timely, complete, and sufficient certification to support the request for leave. The employee should complete this form fully and completely. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. You have 15 calendar days to return this form to your supervisor.

Your Name: _____
 First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

 First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A-QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ☐ Yes ☐ No ☐ None Available

PART B-AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____
Probable duration of exigency: _____
2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ Yes ☐ No.

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ Yes ☐ No.
Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):
Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours _____ day(s) per event.

PART C

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by the County Government to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

PART D

I certify that the information I provided above is true and correct.

Signature of Employee

Date

APPENDIX T



Montgomery County Government Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave (Family and Medical Leave Act of 1993)

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military family leave due to a serious injury or illness of a covered servicemember to submit a timely, and complete certification providing sufficient facts to support the request for leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave The employee or covered servicemember should complete Section I before having Section II completed. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of an employee's FMLA request. You have 15 calendar days to return this form to your supervisor.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTHCARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. **INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Name of Employee Requesting Leave to Care for Covered Servicemember:

First Middle Last

Name of Covered Servicemember (for whom employee is requesting leave to care):

First Middle Last

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

____ Spouse ____ Parent ____ Son ____ Daughter ____ Next of Kin

PART B: COVERED SERVICEMEMBER INFORMATION

- (1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ____ Yes ____ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ____ Yes ____ No. If yes, please provide the name of the medical treatment facility or unit: _____

- (2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ____ Yes ____ No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a United States Department of Defense (DOD) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (VA) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: () _____ Fax: () _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ (VSI) **Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ (SI) **Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ____ Yes ____ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ____ Yes ____ No
If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

- (1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____
- (2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____
- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No
- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No. If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: _____ Date: _____

APPENDIX U
MONTGOMERY COUNTY GOVERNMENT
Employee Request for Family and Medical Leave (FMLA)

Date: _____

TO: (name of supervisor) _____

FROM: (name of employee) _____

Department/Division _____

SUBJECT: Request for Family and Medical Leave (FMLA Leave)

I have worked for Montgomery County for a total of at least 12 months:

___ Yes ___ No ___ Unsure

I have worked for Montgomery County for at least 1040 hours, not including hours of paid leave, during the past 12 months:

___ Yes ___ No ___ Unsure

I need to take FMLA leave because of:

- ☐ the birth of a child, or the placement of a child with me for adoption or foster care;
- ☐ a serious health condition that makes me unable to perform the essential functions of my job;
- ☐ a serious health condition affecting my
 - ☐ spouse
 - ☐ domestic partner
 - ☐ minor child
 - ☐ adult child incapable of self-care
 - ☐ parent;
- ☐ to handle an exigency directly related to active duty status or a call to active duty of my
 - ☐ spouse
 - ☐ domestic partner
 - ☐ son or daughter
 - ☐ parent; or
- ☐ to care for a servicemember with a serious injury or illness incurred in the line of duty while on active duty who is my
 - ☐ spouse
 - ☐ domestic partner
 - ☐ son or daughter
 - ☐ parent
 - ☐ next of kin
- ☐ I need this leave to begin on (date) _____ and expect it to continue until (date) _____ and want to take this leave using:
 - ☐ accrued annual leave
 - ☐ accrued sick leave or family sick leave
 - ☐ accrued personal leave
 - ☐ leave without pay
 - ☐ some combination of the above
- ☐ I need to take this FMLA leave on an intermittent or as needed basis.